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Practices and Women's Perceptions of Childbirth in Western Nepal: A Qualitative Study

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ABSTRACT

Background: Despite continuous efforts to increase the utilization of institutional delivery care services nearly two-fifths women deliver their babies at home without the assistance of skilled birth attendants (SBA) in Nepal. The skilled care at birth can reduce the high maternal and neonatal mortality. This study explored childbirth practices and women's perceptions of childbirth and its associated factors.

Methods: An exploratory study was conducted in three purposively selected remote villages of Kapilvastu district, from March to May 2017. Face-to-face in-depth interviews were conducted with women who had an under-one year child. We performed a thematic analysis to draw the findings of the study.

Results: Women sought institutional delivery care either for long labor-pain or obstructed-delivery. Despite various incentives, people still preferred home for normal deliveries. There was also practiced skilled birth attendant (SBA) assisted home delivery care. Some of the local health workers also advised pregnant-women for assisted home delivery care. People considered childbirth as a normal process. Due to cultural beliefs and norms, people were also reluctant to pursue institutional delivery care services. Financial constraints, poor access to services and expensive transportation services were other underlining causes of home delivery practices.

Conclusions: Despite various incentives for institutional delivery care; the study did not spectacle an encouraging reaction. It pointed to the very basic and strong relationship between women's position in the household and the society and education with childbirth practices. There were limits to how far financial incentives can overcome these obstacles. So, the improvement of the socio-economic conditions of the women would be the viable way-out of the problem.

Keywords: Childbirth practices; home delivery; institutional delivery; women's perception

INTRODUCTION

Maternal mortality ratio(MMR) is still high in under developing countries; around 800 women die every day by pregnancy-related complications worldwide which can avoid providing basic maternal health care services.[1,2] Although maternal mortality has declined gradually from 1990 to 2015.[3] It is not enough to reduce MMR 70 per 100000 live births the target of Sustainable Development Goal (SDG) Three. The low utilized institutional delivery care service was one of the major contributing factors of the high MMR in developing countries.[4,5]

Despite various maternal health care incentives and women empowerment efforts, many women are restricted in decision-making on the utilization of health services. Six women die per day by pregnancy-related causes in Nepal.[6,7] Sixteen percent of pregnant women never sought antenatal care, more than 40% of women delivered their babies at home and nearly one-fifth of mothers received their first postnatal check-up within two days of delivery from 2006 to 2016.[7] So, this study explored the childbirth practices, women's perceptions of childbirth and its associated factors in Kapilvastu district of Nepal.

METHODS

An exploratory study was conducted at three remote purposively selected villages of Kapilvastu district from March to April 2017. We fixed the study sites considering the high prevalence of home delivery practices and poor

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access to health facilities. We interviewed 33 mothers who had under one-year babies considering their age, education, decision-making role and economic status using an unstructured guideline. The guideline was translated into Nepali language and back-translated into English for assuring the translation. We piloted it at a similar village of the same district for exploring the content coverage, required time for the interview and identify more probing questions.

The study proposal was reviewed and granted ethical clearance from the Ethical Review Committee of Pokhara University. We approached the participants with the help of female community health volunteers, obtained informed consent and interviewed them maintaining their rights and confidentiality. Principal investigator himself interviewed mothers who were Nepali native speakers. For interviewing Awadhi and Hindi native speaker mothers, we employed trained female local health workers. Information was captured using the audio-visual recorders, field notes and daily diaries.

After completion of the fieldwork, first, we prepared a script in the Nepali language and translated it into English. The script was processed considering thematic analysis using WEFT software. Initially, we identified semantic themes and latent themes to explore the underlying information. We further considered comments/reactions like a happy face, crying/weepy voices during analysis.

We read and become familiar with the script to generate codes that revealed similar information to create sub-categories. After recognizing of sub-categories, we generated categories which represented similar meaning. We further extracted themes merging subcategories and categories which were created previously that reflect childbirth practices of the community and women's perception towards childbirth. After identification of final subcategories, categories, and themes, we reproduced final results and further correlated acquired information and expressed statements with each sub-category, category, and theme. Finally, we fixed two themes, five categories, and 26 subcategories from the numbers of codes. We also used verbatim and other narrative information for further interpretation of the information.

For the validity and reliability of the information, we measured in terms of trustworthiness which comprises credibility, transferability, dependability, and conformability. The problems related to trustworthiness were addressed throughout the research process. We conducted interviews using a guideline in their native languages, i.e. Awadi, Tharu and Nepali and recorded in their own words. We interviewed women in a comfortable environment to ensure open discussion and encourage all participants to describe their experiences.

We discussed with the participants for ensuring their response and participation in the study. For ensuring the dependability of the findings the same guideline was used consistently and asked the same questions in a similar manner to all participants. We checked the accuracy and consistency of the translations. Conformability was gained through checking and rechecking of the script and reanalyzing the results direct supervision and involvement of the principal researcher.

RESULTS

In rural areas of Kapilvastu district, people considered the childbirth as a spontaneous process and opposed institutional delivery care for normal delivery. Women intended to deliver their child at home due to financial constraints, cultural beliefs, and practice, long distance to the health facility, lack of transportation and dissatisfaction with local providers. Women preferred the health workers/SBAs assisted home delivery care. Some of the local health workers also encouraged women for assisted home delivery during antenatal visits instead of suggesting for institutional delivery.

For generalizing the explored information of childbirth practices and women's perception towards it; we created codes, sub-categories, categories, themes (Table 1).

Women considered childbirth as a normal process. Hence, they neither sought institutional delivery care nor SBA assisted home delivery care for normal delivery care. Family members were also reluctant to pursue institutional delivery care due to their cultural norms, beliefs, and practices. The financial hardship and poverty were other crucial barriers to seeking intuitional delivery care.

"... I had continuous labor pain for two days; however, I was unable to bear my baby. My husband was in India for employment, I request my parents-in-law for bringing me to the health facility. Due to high transportation

expenses, they refused. I called my father and he brought me to Aamda Hospital Butwal and I had a caesarian section there ...” A woman had a caesarian section (CS) after long labor pain.

Due to poor access and high cost of transportation, women preferred to home delivery care for short labor pain and labor pain initiated at night time.

“... when my labor pain started I requested my parents-in-law to bring me to hospital. However, they declined and enforced me for home delivery. My baby had the inverse presentation and I was not able to deliver. The next day only they brought me to hospital, unfortunately, my baby already died...” A woman had a stillbirth in the hospital after a long labor pain.

Terai castes people preferred home delivery than migrated people due to their cultural values and beliefs. They considered hospital delivery against their religion, culture, beliefs, norms and financial burden of the household. Some women were interested to go to the hospital for delivery care. However, family members enforced them for home delivery. Poverty is a bottle-neck issue in the community; most of the households had catastrophic expenditures when they attempted to institutional delivery care services.

“*… We wanted to bring her to the hospital. But we did not have money to pay ambulance and other private vehicles they charged at least NRS 3000 to 5000 (nearly 30 to 50 USD) thousand per trip. We waited a long time, she was not able to bear a child at home and we borrowed money from our neighbors and relatives then we brought her to Amda Hospital Butwal. She had borne a baby by caesarian section…*” Mother-in-law of a woman who had CS after long labor pain

Antenatal care is considered as an entry point of maternal health care. Women who did not utilize antenatal services as prescribed time and number were at risk of home delivery practices. They delivered their baby at home either alone or with the help of untrained traditional birth attendants/neighbor or relative women due to the high cost of transportation, assisted home delivery care and institutional delivery care.

“… I had labor pain in the late evening. My family members wait for a long time but I was not able to give birth to my baby. We did not manage any vehicle in beforehand, there was heavy raining. We contacted different ambulances. Unfortunately, we did get an ambulance at night time. We waited the whole night my baby presented inversely. The next morning my brother went to Chanauta and brought a private jeep and we went Butwal and I had assisted delivery. However, my baby already dead…” A woman had assisted stillbirth in the health facility.

Religious and cultural practices and beliefs were the other underlining causes of home delivery. People were not assured of their personal privacy and confidentiality in the health facility. For the continuity of their socio-culture beliefs and practices, people forced women for home delivery practices. Education status, autonomy at the household, access to information about delivery care, benefits of institutional delivery care and available delivery incentives were major influencing factors for seeking institutional delivery care.

“… I give birth to a child at home after long labor pain. My family members compelled me to give birth at home. They did not allow me to take SBA care. I did not have any right to take care of myself. She said with a crying voice…” A woman had who home delivery after long labor pain.

Educated women considered childbirth as a critical condition and they sought institutional delivery care services. Literate, autonomous and financially sound women prompted to seek the institutional delivery than their counterpart.

“*…although I wanted to give birth to my child at a hospital. Due to the absence of birthing centers in local health posts and the economic problem I was unable to do so. Ultimately, I compelled to go hospital due to my obstructed delivery …”A* woman who had CS after long labor pain.

Childbirth practices were determined by the perception of pregnant women and their families, existing delivery practices and available health care facilities at the community level, and the needs and nature of delivery care (Figure 1).

Table 1. Thematic organization of the information.

Themes	Categories	Sub-categories
Delivery practices	Home delivery	Childbirth is a normal process
		A child born with short labor pain, labor pain starting at night-time
		A cultural preference
		The family's reluctant or poor support
		Long-distance to the health facility and lack of transportation
		Financial constraints
		Low education status/illiteracy
		Poor access and utilization of antenatal care services
	Health worker/SBA assisted home delivery	Locally/easy access
		Cheaper compared to institutional delivery
		Encouraged by health workers/SBAs during ANC
	Delivery at a health facility	Long labor pain or obstructed labor
		Educated women and sound economic condition
		Close distance to the health facility
		ANC and delivery incentives including free delivery care services
		Opening hours and availability of the providers at the health facility
		Ambulatory care/transportation facilities
Women's perception of childbirth	Normal phenomenon	Sociocultural norms and beliefs
		Low educational status and less autonomy
		Poor information on ANC and delivery care incentives
	Critical condition	Educated/empowered/autonomous women
		Access to service and information
		The complicated history of childbirth

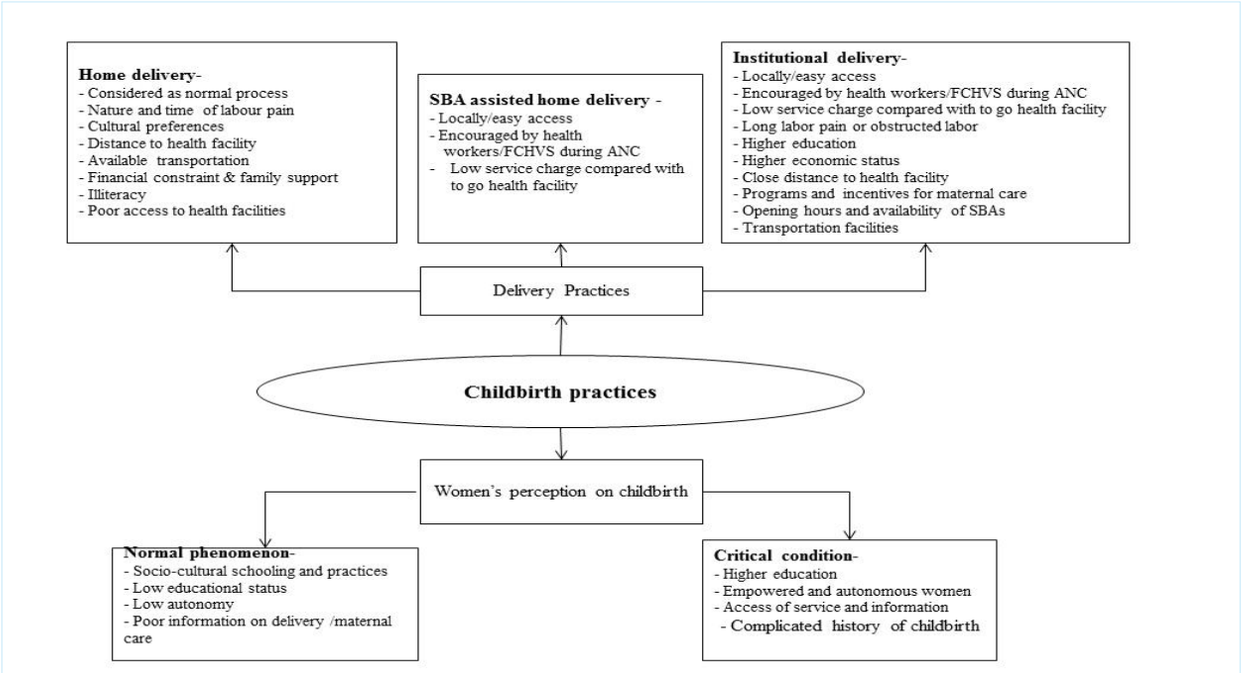

Figure 1. Conceptual pathway: Childbirth practice and women's perception about it.

DISCUSSION

Women perceived childbirth as a normal phenomenon and preferred home delivery rather than institutional delivery in the remote part of Kapilvastu district. People gave first priority for home delivery in the normal condition. They only sought institutional care in case of long labor pain or obstructed delivery. Illiteracy and poverty enforced people to deliver their babies at home. Some women had information on the safe delivery care incentives of the Government of Nepal, but many pregnant women were not advised clearly during antenatal visits for seeking institutional delivery care and available incentives.

Women were enforced to bear a child at home by parents-in-law and other family members. They also regarded intuitional delivery as cultural taboos and continued unsafe home delivery. At remote villages of Mugu district of Nepal had the same condition where the delivery was considered as a natural process and women did not visit health facilities for normal delivery care. Regarding the culture faith and practices, they preferred home delivery. They also believed that to make happy their gods and preserving the culture they wanted to continue home delivery.[9] Socio-cultural factors and economic and physical accessibilities had the prominent role in the utilization of maternal health care services in low-income countries.[10]

Low access to health facilities, poor road transportation, and expensive service charge, private transportation, and ambulance service were other predisposing factors of the home deliveries. Closeness to health facilities and better transportation facilities positive influence in the utilization of maternal health care services.[11-13]

Despite the interest of institutional delivery, women had born their child at home due to the financial constraints and reluctance of family. In India, the utilization rate of institutional delivery care and other maternal health services differed from the place of residence, socio-economic and education status, religion, and caste. Muslims, other scheduled and backward castes were less likely to use safe delivery care. The teenaged women of southern India were more likely to seek maternal health care services compared to other parts of the country.[14]

Educated, financially sound and ANC utilized women prompted to seek skilled care at birth. Distance to the health facility, dissatisfaction with the providers and physical facilities were prominent hindering factors in the low utilization of institutional delivery care services in the study areas. Prior studies revealed that high age, low socio-economic status and low education status of women, high parity, gender inequality, traditional socio-cultural practices, the low decision-making power of women were other contributing factors of the low utilization of institutional delivery care.[7,10,15]

Women perceived childbirth as a usual event of their reproductive life and happened normally. Reproductive-age women and their family members were not conscious of the lifetime risk of the pregnancy and its consequences. Despite the policy provision, women's choices and safety needs there was a complex relationship between childbirth practices, culture and the utilization of maternal health care services at birth in Nepal.[16] Women affirmed that traditions, values, and beliefs as constructive contributors to their safety and survival of their babies during pregnancy and childbirth.[17,18]

This study was conducted in Kapilvastu district which is one of the low-performance districts and had low Human Development Index ranking staus.[7] From the study, we developed a conceptual framework for stating the underlying factors of childbirth practices. It covered only the qualitative dimensions of childbirth practice. We suggest mixed methods studies for the further precise exploration of the practices, access to delivery care services, socio-economic status, and cultural and political issues of women's health and its influence on childbirth practices and women's perception towards it.

CONCLUSIONS

Home delivery care practice was found prevalent among illiterate and financially weak women compared to their counterparts in the remote areas of Kapilwastu district, Nepal. Amongst various determinants of the childbirth practices for seeking institutional delivery care: easy access to health facilities, availability of ambulance services and public transportation, antenatal care, family support, women's autonomy in decision-making, financial resources and freedom for movement were other key influencing factors of childbirth practices. Women perceived childbirth as a natural process and did not follow the skilled care at childbirth. Despite the intensive implementation of incentive programs to increase the utilization of skilled care at birth and institutional delivery, the study does not show an encouraging response. Education and economic status of women were major dominant aspects of the home delivery practices and women's perception of the delivery care. For changing their perception towards traditional childbirth practices and improve the institutional delivery care, improvement of the educational and economic of women would be the viable

way out of the problem.

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